NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH PERSON AGE EIGHTEEN (18) OR OLDER

In the event that you wish to have someone other than yourself (or your employer) contact Allegiance regarding your flex account, please complete this form. The form will not be accepted without notarization. Thank you.

AUTHORIZATION TO RELEASE CONFIDENTIAL MEDICAL AND CLAIM INFORMATION

Name of Employer Plan: _____ Group Number: _____

Name of Covered Person: _____ Social Security Number: _____

Name(s) of Dependent(s)	Birth Date(s) of Dependent(s)
_____	_____
_____	_____
_____	_____
_____	_____

As the Covered Person under the employee health and welfare benefit plan shown above, I hereby authorize Allegiance Benefit Plan Management, Inc., to release confidential medical and/or claims information to _____,

whose relationship is _____to the Covered Person listed above.

I agree to indemnify and hold the Plan Supervisor harmless for confidential medical and/or claims information released to the named individual based upon this authorization. This signed authorization will remain in effect until affirmatively revoked by me in writing. This authorization may be revoked at any time by sending written notice to the third-party claims payor, except that this authorization cannot be revoked retroactively after action has taken place, such as releasing information to the above named person, in reliance on the authorization.

_____ _____
Signature of Covered Person Date

STATE OF _____

COUNTY OF _____

Signed and acknowledged by _____ who provided proof of identification and who personally appeared before me, a Notary Public, this _____ day of _____, 20____ .

(SEAL)

_____
Signature of Notary Public

My commission expires _____